Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1
HWB	**Torbay Council**
ICB	**NHS Devon**

Section 1: Overview of BCF Plan

This should include:

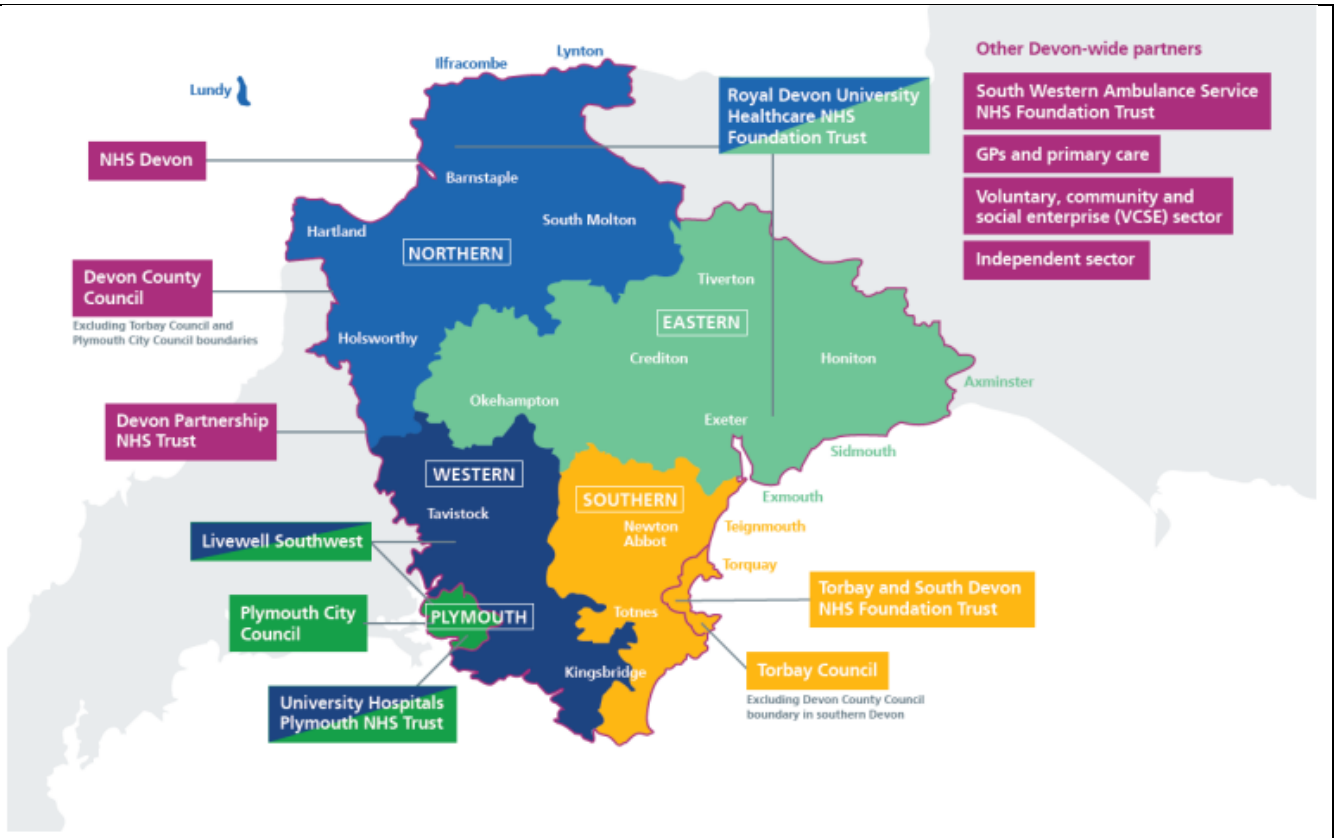
- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

Priorities for 2025-26

The Devon Integrated Care System, "One Devon, Five-Year Joint Forward Plan, 2025-2030, sets out how we will work together across the health and care system to respond to the One Devon Integrated Care Strategy. This plan brings together the collective ambitions of NHS organisations, local authorities, and other system partners to ensure a coordinated and aligned approach to improving health and care services for the people of Devon.

Devon is a complex Integrated Care system, with many different arrangements delivering functions across a unique geography. Elements of the plan are delivered across a range of provisions including:

- Two unitary authorities (Plymouth City Council and Torbay Council). • One county council (Devon), with eight district councils.
- 117 GP practices across 31 Primary Care Networks (PCNs) .
- Devon Partnership Trust (DPT) and Livewell South West (LWSW) provide mental health services.
- Four acute hospitals – North Devon District Hospital and the Royal Devon and Exeter Hospital, both managed by the Royal Devon University Healthcare NHS Foundation Trust (RDUH), Torbay and South Devon NHS Foundation Trust (TSDFT) and University Hospitals Plymouth NHS Trust (UHP).
- One ambulance trust – South Western Ambulance Service NHS Foundation Trust (SWASFT).
- Dental surgeries, optometrists and community pharmacies.
- A care market consisting of independent and charitable/voluntary sector providers.
- Many local voluntary sector partners across our neighbourhoods.



The JFP consolidates various local plans across the system, including, but not limited to:

- The NHS Devon Annual Plan.
- NHS Operational Plans.
- Joint local health and wellbeing strategies.
- Plans developed at a Local Care Partnership (LCP), Provider Collaborative and NHS Provider level.
- Internal local authority plans (e.g., adult social care, children's services).
- Better Care Fund Plans contribute to the effective delivery and shaping of resources.

One Devon main challenges

There are consistent challenges found across the Devon Integrated Care System footprint. These includes:

- An ageing and growing population with increasing long-term conditions, co-morbidity and frailty.
- Climate change.
- Complex patterns of urban, rural and coastal deprivation.
- Housing quality and affordability.
- Economic resilience.
- Access to services, including socio-economic and cultural barriers.
- Poor health outcomes caused by modifiable behaviours and earlier onset of health problems in more deprived areas.
- Varied education, training and employment opportunities, workforce availability and wellbeing.
- Unpaid care and associated health outcomes.
- Changing patterns of infectious diseases.

- Poor mental health and wellbeing, social isolation, and loneliness.
- Pressures on health and care services (especially unplanned care).

Our Joint Forward Plan

Priorities for the Joint Forward Plan are set out below. As with previous years the JFP continues to focus on; improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development. Each aim includes a series of programmes. Programmes of particular importance to achieving Better Care Fund outcomes and delivery within Health and Wellbeing Board footprints are; Community services and Urgent and Emergency Care.

Vision	Equal chances for everyone in Devon to lead long, happy and healthy lives			
Aims	Improving outcomes in population health and healthcare	Tackling inequalities in outcomes, experience and access	Enhancing productivity and value for money	Helping the NHS support broader social and economic development
Themes	**Healthy People**	**Healthy, safe communities**	**Healthy, sustainable system**	
Programmes	Primary Care and Dental	Housing	Clinical Service Change	
	Community Services	Employment	System-wide productivity and efficiency	
	Elective Care	Suicide Prevention	Integrated clinical support services	
	Urgent Care	Green Plan	Shared non-clinical support services	
	Children and Young People	Health Protection	Clinical Effectiveness, research, Innovation & Improvement	
	Maternity, Neonatal and Women's Health		Estates and Infrastructure	
	Adult Mental Health		Workforce	
	Learning Disability, Autism and Neurodiversity		Digital and Data	

Torbay Council's Adult Social Care (ASC) Strategy outlines how we work together to deliver improved adult social care services for residents in Torbay. As part of the strategy, we have co-produced the following priorities. Details of the activities we will carry out to meet these are including in section 2 "priorities for intermediate care".

Priority 1: Helping people to live well and independently.
Priority 2: Helping people to regain their independence

Priority 3: Helping people with care and support needs to live independently, safely and with choice and control.

Underpinning these priorities, we will:

- Develop and grow our workforce; and
- Engage and consult with service users, their families and carers and our partners.

For further detail please see Adult Social Care Strategy - Torbay Council

Our ASC Strategy is supported by our overarching ASC Commissioning Blueprint. It shows the needs and social policy driving adult services in Torbay. Torbay's commissioning approach seeks to:

- Reduce the systemic use of residential care to meet social care needs;
- Increase the use of enabling housing-based models of care and support so that people have a greater choice and control over how, where and with whom they live, as well as who and how their care is provided; and
- Increase the number of people able to maintain their own independence through their own strengths and those in the community around them.

For further detail please see ASC Commissioning Blueprint - Torbay Council

Adult Social Care Transformation

We know that Torbay council have areas of performance that outlie in comparator data. The key areas of concern are Torbay Council have brought a Transformation partner into the Torbay system to identify areas of work that will improve outcomes and cost for Adult social care. The key areas of focus for this work are ensuring appropriate advice, guidance and signposting with a digitally enabled front door into social care, developing a wider and consistent reablement offer to all people who have potential for recovery/improvement before commissioning a service, improving our TECH for people who draw on services, review of practice, process and legal literacy and finally streamlining Hospital discharge processes.

Alongside this there needs to be a continued focus on the role of commissioning in shaping the market and the range of products that are available to ensure we support people in the least restrictive way by building confidence in TECH, Enabling and Direct Payments to ensure our key objectives around strength based, person centred and outcome based approaches are taken alongside appropriate formal support commissioned by the LA when needed.

Key changes since the previous plan

As with previous years plans (23-25), the BCF has been developed jointly by local authorities and NHS Devon colleagues and will continue to facilitate collaborative working across partners and stakeholders within the Devon ICS footprint.

Torbay has a strong history of integrated working and can be proud of the many benefits that this brings to residents, our services and the ICS. Within Torbay delivery of acute health, community

health and social care have been delivered by the pioneering arrangements with the integrated care organisation, Torbay and South Devon NHS Foundation Trust which brings many benefits to people, services and the system. This includes benefits from integration, improved collaboration between services, standardisation of pathways across different sectors, development of new ways of working for our collaborative workforce and importantly delivering better continuity of care for our local population.

Since the 23/25 submission there has been significant development as an integrated care system and within our local care partnerships, as well as embedding our overall Devon ICS Strategy and Forward Plan.

The BCF plan will support the One Devon Joint Forward plan and address the inconsistences in access and availability in our communities, as we learn from them as to how best the BCF can meet local need. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi, the absolute and relative proportion of our lives spent in ill-health has increased.

Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care.

The **Neighbourhood Health Guidelines** set a framework for how systems can move towards a community-centric model of healthcare delivery, working towards achieving the **three strategic shifts** set by the government for the NHS in 2024. This will enable systems to build services tailored to local needs, existing infrastructure and relationships with the overall focus being to set the foundation for the neighbourhood model in the future. The ICB are working with community partners to look at developing a roadmap for the development and delivery of Neighbourhood Health Services to get a position on the strengths and assets we already have in each LCP.
NHS-England-Neighbourhood-Health-Guidelines-for-2025-26.pdf

Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception. Some places have already made progress in developing an integrated local approach to NHS and social care delivery. The full vision for the health system will be set out in the 10 Year Health Plan, including proposals to help make this emerging vision for neighbourhood health a reality, informed by existing work and public, staff and stakeholder engagement.

As part of the wider transformation work being undertaken in Torbay, we are reviewing the costing models we use to determine fee rates for Older People (OP) care homes (residential and nursing). Establishing the price paid for this care is important to secure services, manage our budgets, seek to understand provider costs, and maintain a good relationship with our care homes.

As commissioners of adult social care this will enable us to better secure value for money services within our care homes, to support hospital discharge for those people where residential care is still appropriate.

Market Development to support complex discharges, keeping people well and independent in the community

We are developing a ***Supported Living complex tier framework*** to ensure appropriate and effective commissioning within our supported living for people with complex care needs. This will support both the LA and NHS to manage outcomes for people who require higher and bespoke packages.

We are working on a specification to develop a wider ***reablement model*** that would serve to change wider culture within our domiciliary market away from relying on an ongoing time and task model. We are looking to develop a partnership that will provide closer working with our MDT's working to set care goals with some of our providers delivering outcome focused work to reduce ongoing dependencies by focusing on regaining independence for individuals by using TECH, engaging the voluntary sector and using care to regain key mobility, functional and cognitive skills that in turn build confidence for people following a health or social care event.

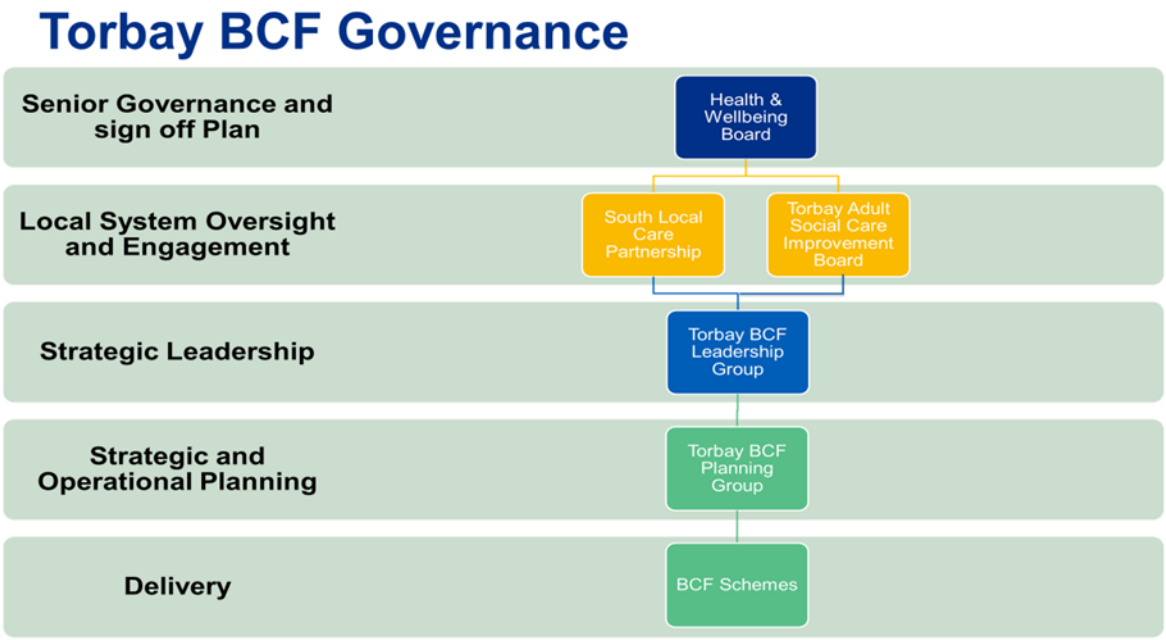
Approach for the development of plan and governance

- Outline the process used for the development of the plan, including stakeholder engagement in local health and care plans and use of data and insights.
- The governance structure in place and roles and responsibilities of partners
- Partners commitment to continuous learning and improvement, including engaging with enhanced support and oversight from the BCF programme if needed

The One Devon Partnership is responsible for developing the Integrated Care Strategy for the Devon ICS footprint and works together as NHS, local councils, voluntary sector, and many other stakeholders as outlined below:

There are five established local care partnerships (LCPs) that when combined form the whole of One Devon Integrated Care System, of these one (South LCP) encompasses the Torbay Council and

Torbay Health & Wellbeing Board footprint. The governance arrangements for Torbay's Better Care Fund (Torbay Council footprint) is shown below:



The process to develop Torbay Better Care Fund Plan 2025-26 has included:

- Planning and review - undertake development of BCF plan narrative, review current delivery and proposed strategic direction to ensure alignment of Torbay BCF to local, Devon ICS and national priorities.
- Financial review of 2023-24 schemes for investment to identify alignment with revised BCF national objectives
- Capacity and demand – modelling demand and capacity across pathways 1 – 3 and ensuring capacity of therapeutic support and workforce models in considered within projections for 2025-26
- Metrics – alignment of new BCF metrics with NHS operating plan and Adult Social Care monitoring.

The process has been:

- overseen, monitored and co-ordinated by Torbay BCF Leadership Group.
- Engagement of system partners has been managed through the above activity, Torbay BCF leadership Group, South Local Care Partnership and Torbay Health and Wellbeing Board
- Torbay BCF leadership group agrees the final version of the BCF plan prior to internal organisational agreement within NHS Devon, Torbay Council and Torbay and South Devon NHS Foundation Trust.
- Torbay Health and Wellbeing Board is responsible for formally signing off the Better Care Fund Plan, monitoring and scrutinising delivery.

The Torbay system is committed to continuous learning and improvement. During 2024-25 Torbay BCF has welcomed the introduction of BCF quarterly assurance meetings with regional BCF leads. Torbay will continue to fully engage in these collegiate conversations and engage in enhanced support and oversight from the BCF Programme where required.

Alignment with plans for improving flow in urgent and emergency care services

A key system priority remains addressing the urgent care and system flow challenges frequently being experienced across Devon ICS and the impact delayed discharge has on the whole system flow. The success of delivering the Devon Urgent and Emergency Recovery Plans relies heavily on ensuring the integrated community services supported by the BCF remain responsive to the continued high demand and be able to enhance the support at times of greater pressure or demands across the care pathway. Transformation of these services, focussing initially on hospital discharge, will bring significant improvements to the experience of all those transitioning through our integrated health and social care services.

The Better Care Fund plan supports the strategic delivery of joint system, NHS and Local Authority priorities. The BCF recognises the priorities outlined in the NHS Operating plan and the need to:

- Reduce the time people wait for elective care.
- Improve A&E waiting times and ambulance response times compared to 2024/25.
- Improve patients' access to general practice.
- Improve patient flow through mental health crisis and acute pathways.

Addressing the BCF objectives; reform to support the shift from sickness to prevention and, reform to support people living independently and the shift from hospital to home will help to focus improvements particularly relating to improving A&E waiting times and patient flow through mental health and acute pathways across Devon. BCF planning, implementation and delivery is an integral part of wider system planning to deliver system wide improvements.

The BCF plan and investments has a strong focus on; supporting and developing intermediate care, ensuring capacity and sufficiency of complex discharge pathways and focusing on integrated health, social care and VCSE working to support admission avoidance. This sits within and is complementary to Across the Devon ICS footprint and complementary to achieving the BCF objectives, as a system we will:

- Optimise **UEC demand management initiatives** by implementing the Neighbourhood health core components, including embedding an approach to population health management, risk stratification and whole pathway working for vulnerable groups including frailty and respiratory.
- Improve **access to urgent care outside of hospital** through urgent treatment centres, mental health crisis resolution and home treatment teams, virtual wards and urgent community response teams.
- Join up urgent & emergency care services through a **single point of access** that is accessible to ambulance services and ensuring urgent community response services enable ambulance services to **increase see & treat** activity.
- Apply **'discharge to assess'** principles, aligned to the Better Care Fund objectives and goals, by: assessing people's short-term recovery needs at home where possible immediately after discharge; conducting longer-term care assessments following an initial recovery period.
- Address **inequalities** within the UEC pathway, ensuring parity of esteem for patients with urgent mental and physical health needs, and consider the needs of those who make high

intensity use of emergency departments. Apply best practice to reduce long waits for patients presenting in ED with mental health needs, including use of UEC mental health action cards.

The Devon System Coordination Centre (SCC) sits at the centre of our approach to ensuring and improving flow in urgent and emergency care services. The SCC serves as a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible. The SCC is responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies. The OPEL Framework contains specified and incremental core actions for the SCC at each stage of OPEL. The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow. The function of the SCC ensure a concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

Through a joined up collaborative approach, the SCC supports proactive co-ordination of a system response to operational pressures and risks. The SCC utilises available information and intelligence to assess and validate local assurance submissions with regards to planning for events that impact on UEC and wider system pathways that require specified operational planning. Through daily system calls, the SCC, through its Visibility of operational pressures and risks across providers and system partners ensures that Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges can de be response to in a Dynamic approach, and where required will leverage services which are directly/indirectly supported through the BCF schemes.

Locality representatives from the ICB across our three HWB footprints actively feed in and support the SCC in ensuring the Local system challenges are supported thought providing targeted interventions and speciality knowledge to ensure to Flow out into our community services as well as ensuring the right capacity is matched against demand to ensure services are delivered as effectively as possible. Examples include, Discharge planning and unblocking barriers to reduce time spent in hospital for our patients.

A brief description of the priorities for improving intermediate care (and other short-term care).

Our plans for Intermediate Care align to those of the national framework which aims to:

1. Improve demand and capacity planning
2. Improve workforce utilisation through a new community rehabilitation and reablement model
3. Implement effective care transfer hubs
4. Improve data quality

Our approach to intermediate care aligns to Torbay Health and Wellbeing Board priorities, in particular, priority Healthy Ageing and associated cross-cutting areas of; good housing, reducing inequalities and supporting carers.

Intermediate Care plans are joint approaches between patients and their families, acute, community health, social care, VCSE sector and wider services to reduce delays in discharge, improve flow and work to a home first approach. Plans continuing into 2025/26 aim to:

- **Reduce Length of Stay**: Increasing the percentage of patients discharged by or on day seven of their admission.
- **Enhance Patient Flow**: Working with local authority partners to streamline discharge processes and reduce the average length of stay.
- **Leverage Digital Tools**: Fully utilizing digital tools to transition from analogue to digital systems, improving efficiency and patient care.
- **Shift from Hospital to Home**: Emphasizing the transition from hospital care to home care, ensuring patients can recover in the comfort of their own homes.
- **Integrate Care**: Enhancing collaboration between health and social care services to provide seamless support for patients during discharge.
- **Provide Support for Independent Living**: Implementing strategies to help people live independently, reducing the need for prolonged hospital stays.
- **Streamlined Processes**: Simplifying planning and reporting processes to improve efficiency and accountability.

This will be delivered by our Hospital Discharge Programme Board. This work will have a particular focus on utilising our revised demand and capacity plan to ensure market sufficiency of pathway 1, 2 and 3 provision, emphasising utilisation of in-house and increasing block contracts to achieve better patient outcome, particularly in pathways 1 and 2. Reablement specifications will continue to be embedded to further support a home first approach. A policy and practice group will ensure adherence to the national intermediate care framework and work to change culture and practice to achieve John Bolton practice models for discharge.

Torbay Council's Adult Social Care (ASC) Strategy further strengthens our joint approach to delivering Intermediate Care service. The Strategy outlines how we work together to deliver improved adult social care services for residents in Torbay. As part of the strategy, we have co-produced the following priorities and the activities which we will carry out to meet these.

Priority 1: Helping people to live well and independently.

- Have strengths-based conversations;
- Provide accessible information, advice and guidance;
- Use our community front door and community sectors; and
- Provide more support for carers.

Priority 2: Helping people to regain their independence

- Provide a rapid/crisis response;
- Increase community reablement; and
- Develop a short-term care centre.

Priority 3: Helping people with care and support needs to live independently, safely and with choice and control.

- Encourage an increase in the use of Direct Payments;
- Enable the provision of extra care and supported living housing options;
- Have good and outstanding care homes; and
- Provide specialist dementia care.

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

Torbay Better Care Fund is committed to delivering the national BCF objectives:

- ***Objective 1: reform to support the shift from sickness to prevention***
- ***Objective 2: reform to support people living independently and the shift from hospital to home***

In developing our plan, we have taken into consideration national guidance linked to Neighbourhood Health Teams, High Impact Change Model along with local plans to avoid unplanned admissions to Emergency Department and reduce the risk of people moving into long-term residential care.

The Better Care Fund Plan aligns to the NHS Operating Plan and should not be seen as independent from the wider system. Torbay BCF is interdependent of wider schemes linked to urgent and emergency care, discharge from hospital, flow management, admission avoidance, prevention and maintenance of health and social care conditions within the community.

Objective 1: Shift from sickness to prevention

Timely, proactive and joined-up support for people with more complex health and care needs

In 2025/26, the Torbay system will build upon the long history of integrated working via the Integrated Care Organisation. Timely, proactive and joined-up support for people with more complex health and care needs will be achieved by implementing the Neighbourhood Health Teams approach. Elements of the 6 core components of an effective neighbourhood health service are in place and well established:

1. Population Health Management
2. Modern General Practice

3. Standardising community health services
4. Neighbourhood multi-disciplinary teams
5. Integrated intermediate care
6. Urgent neighbourhood services

In 2024/25 a community services review was undertaken to better understand and commence standardisation of community services. Population health management approaches have supported communities most in need and supported better population health.

The maturity of PHM has grown in the last 12 months and will continue into 2025/26. PHM in conjunction with primary care Brave AI pilot sites will identify patients most at risk of unplanned admission to hospital in the next 12 months. Multi-disciplinary teams including primary care, social care, community health and VCSE organisations will plan joint approaches to manage patients holistic needs to manage ill health and prevent needs escalating.

Intermediate care and urgent neighbourhood services such as urgent community response and home from hospital (virtual ward) services are well established and improvements has been made to increase the number of clients engaging with UCR, increase virtual ward bed numbers and occupancy to work towards and achieve national targets.

Work has now commenced, bringing system partners together to effectively map services and pathways aligned to neighbourhood health teams. A detailed plan will be developed in 2025/26 to formally develop and commence the implementation of a new neighbourhood model of care.

Investments being made specifically by Torbay BCF to support this objective includes Baywide Intermediate Care service, Front End Services - First point of contact for social care, including social care navigation through improved information, advice & guidance.

Use of home adaptations and technology

Home adaptations and technology are key enablers to maintaining independence and supporting a shift from sickness to prevention. The Disabled Facilities Grant will continue to be invested in Torbay's population. Community health and social workers will continue to support and direct clients to the disabled facilities grant in cases where assessments indicate the need for home adaptations. The number of clients using TEC enabled care has increase from 1200 to just over 1600 people between April 2024 – December 2024. Further investment into TEC enabled care is being made by Torbay BCF in 2025/26.

Support people living independently and the shift from hospital to home

Prevent hospital admission

Much of what has been discussed above will support prevent hospital admissions. In addition to this a coherent Devon wide programme of Emergency Department Demand Management is being undertaken. Approaches to prevent hospital admissions includes:

- Increase GP capacity to deliver a Same Day Primary Care Hub pilot
- Delivery of enhanced health in care homes to provide a more proactive approach to managing the health needs of care home residents
- Ensure sufficient capacity within Urgent Community Response

- Delivery of Care Co-ordination Hub model sees the ambulance service stream suitable 999 calls to expert clinicians who can advise, prescribe and refer to appropriate primary and community pathways.
- Delivery of High Intensity Users Programme to understand the reason for repeat attendance in ED and support the client with the route cause and wider social determinants which may be driving behaviours.
- Same Day Emergency Care and Frailty Same Day Emergency Care diverting patient appropriately away from Emergency Departments to have their needs met by clinicians via an alternate model of care.

Achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)

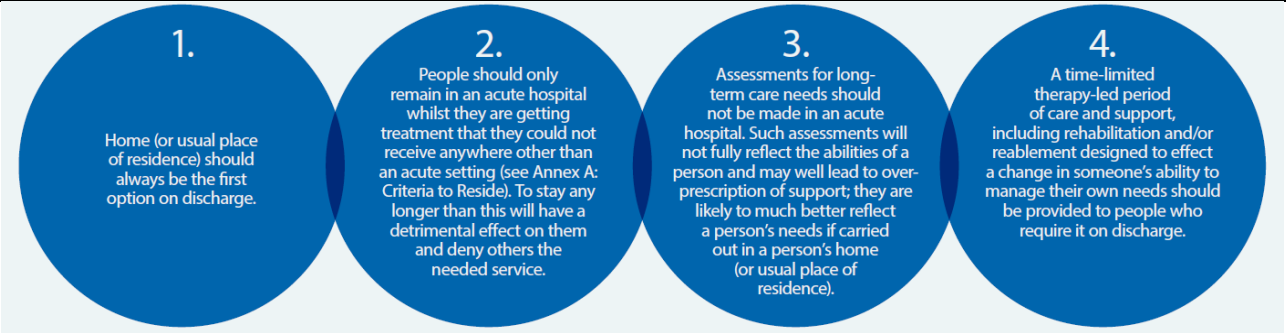
Across Devon ICS footprint we operate a Discharge to Assess model for acute hospital discharges. This ensures all individuals have an appropriate short-term need identified and coordinated through a Discharge Transfer Hub, pending longer term assessment following an initial recovery period. We promote a Home First approach to maximise the proportion of individuals who are discharged back to their usual place of residence. Funding, commissioning and performance management for this is managed through the local Better Care Fund arrangements.

Early discharge planning is managed within the acute setting:

- Through use of computerised notes, the HDT (Hospital Discharge Team) can be alerted to frequent attenders through use of flags on notes.
- Hospital discharge attendance at board rounds to hear about the complex patients prior to them being medically fit for discharge
- Good links with the avoidance teams who will alert issues early on in patients' journey
- Attendance at 7 day stay meetings which highlights the most complex patients. HDT alongside site management teams on ward will set up weekly MDT to ensure D/C plan on track
- Community teams in-reach and link with staff on ward re patients known to them
- Education/training to new employees- nurses and therapists that Discharge is everyone's responsibility
- Daily MDT with community teams -allows team to be alerted by them if a complex community patient is admitted
- Early referral to the Hospital Discharge Team is encouraged for complex patients

Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

At the heart of our approach to Hospital discharge and intermediate care is through establishing a Home first approach. The Torbay Health and Wellbeing Board footprint for hospital discharge is delivering the Home First / discharge to access.



This incorporates the following principles

- Home First will truly be the first option.
- Supported by the reinforcement of a Home First culture, maximising opportunities for our discharge coordination hub, and ensuring access into pathway 1 is as efficient as possible.
- Our therapy teams will work in a more integrated way across acute and community teams to improve outcomes for individuals.
- We will move to services designed around a neighbourhood footprint, underpinned by a PHM methodology to offer appropriate services that respond to local needs operating in an integrated way.
- Ensure referrals can be made directly from the community (step-up) or as part of hospital discharge planning (step-down), applying a 'Home First' approach, with assessments and interventions delivered at home where possible and working closely with urgent neighbourhood services.
- From an Adult Social Care perspective and reversing the principles of a Home First approach, we will strengthen and ensure adequate and timely access to a social care re-ablement front door offer.

Discharge to assess model improvements to be made throughout 2025/26 are:

1. Establish robust demand and capacity plans to ensure market sufficiency for P1-3 discharges across Devon ICB footprint.
2. Ensure robust and consistent data collection within acute providers to support accurate data recording and reporting against BCF metrics, with a particular focus on discharge to normal place of residence, NCTR and delays from discharge ready dates.
3. Review current VCSE capacity and delivery to inform a future VCSE discharge support model across Devon ICB
4. Learning from early adopter areas in Devon, develop a revised pathway 1 reablement specification and contract to achieve consistent outcomes across Devon ICS.
5. Consolidation of pathway 2 provision across Devon ICB including a review of capacity and P2 therapeutic models across localities, understand impact of P2 reablement block contracts procured in 2024/25 and define further commissioning intentions for 2025/26 working towards John Bolton / IPAC models within localities.
6. Focus on shifting pathway demand from pathway 2 to pathway 1 and reduce lengths of stay across all pathways, including, improving assurance of quality of discharge (Devon Transfer of Care programme outputs) and better reporting/monitoring aligned to NHS Devon Patient Safety Quality team.

7. 25/26 will see the creation of a bespoke pan-Devon End of Life discharge pathway.

Reduce the proportion of people who need long-term residential or nursing home care
The discharge to assess model is key to reducing the proportion of people who need long-term residential or nursing home care. There is still much work to be done to ensure patients are discharged on appropriate pathways and to continue to work towards achieving the Prof John Bolton, best practice models for discharge. However, we have strong foundations to continue this work.

Our approach includes discharge transfer of care hubs manage the discharge process. In-reach models are utilised with therapeutic input to better identify and ensure patients are discharged on appropriate pathways and maximises opportunity for reablement and discharge to normal place of residence. Trusted assessors are in place working in partnership with care providers to assess, manage and expedite discharges.

The focus of the last 12 months has been to commence implementation of reablement models of care, initially focusing on pathway 2. Early data indicates only 2% of patients move on to long-term residential care when discharged from a P2 block booked therapeutic led reablement bed. Further embedding this approach into 2025/26 will continue to support a reduction in utilisation of long-term residential care.

Aids and adaptations delivered through community equipment service contracts successfully contribute to discharging to a person's normal place of residence. Adaptations via seizure sensors through to specialist beds support a person to return home and increases opportunity to remain at home and reduce the risk of long-term residential admission.

Value for money
The Torbay approach to the development and deployment of our Better Care Fund centres on a clear evaluate and review methodology that ensures we take the learning from each years Better Care Fund into our development of subsequent year's plans. The governance infrastructure outlined within section 1, describes a close alignment to the delivery of the BCF and our local place-based arrangements, the South Local Care Partnership. Aligning our BCF approach and our place-based development forums ensures that we engage the full range of system partners (including health, social care, acute, community, VCSE and carers) and responds to local strategies as set out across the Integrated Care Strategy, Joint Forward Plan, Adult Social Care Strategy and Commissioning Blue Print (see section 1).

For 2025/26 planning purposes we have undertaken an extensive review of current investments to understand impact of delivery and check alignment against the updated BCF objectives and ensure they support delivery of the updated BCF metrics. As can be seen this has led to a degree of consolidation of previous investments, whilst ensuring many of high performing schemes have continued, we have shifted further investment into our homebased reablement offers. This will ensure we continue to deliver against the ambitions set out within our Intermediate Care Plan and the BCF plan for 25/26 by increasing the proportion of individuals who are discharged back home following a hospital stay and increase capacity for individuals to be supported at home during a period of escalation/crises. This work closely follows national best practice and capitalises on the

success we have had over the last year in optimising discharge pathways. Our performance over the last year and ambitions for our metric delivery over the next year reflect this.

Our review ensures we maximise value for money of investment. As can be seen a number of schemes funded last year have been stood down and we have re-focused investment to maximise the resources we have available. We have carefully considered our demand and capacity planning and have commenced a process to establish a home-based intermediate care offer that will place less reliance on costly out of area/agency resource.

The plan describes a set of investments that offer targeted and coordinated interventions for people living in the community to ensure they are supported to remain at home wherever possible, delivering the shift from hospital to home. Our proposals reflect recognised best practice models.

Consolidation of Discharge Fund

The 2025/26 Better Care Fund Policy Framework consolidated the Local Authority and ICB Discharge Funds into the NHS Minimum contribution and Local Authority Grant. The rationale for this was to provide greater flexibility in areas of investment.

The Hospital Discharge programme remains an important and central part of Better Care Fund plans in Torbay. In line with our intermediate care plan and the continued delivery of this into 25/26 and following a review of schemes, Torbay Better Care Fund will continue to retain, as a minimum, a budget in-line with BCF funding allocations. For Torbay the combined discharge allocation is £3,913,023.

By utilising our revised demand and capacity plan we will:

- Ensure market sufficiency of pathways 1, 2 and 3 provision.
- Emphasise utilisation of in-house and increase block contracts to achieve better patient outcome, particularly in pathways 1 and 2.
- Reablement specifications will continue to be embedded to further support a home first approach.
- We are increasing the proportion of investment that focuses on pathway 1. We will launch and embed the new P1 model post procurement.
- We will also continue with our pathway 2 reablement specification to continue to drive improvements in patient care.
- A policy and practice group will ensure adherence to the national intermediate care framework and work to change culture and practice to achieve John Bolton practice models for discharge, receive appropriate community support to prevent readmission or transition from P2 to long-term residential care.
- Changes will be made at a local level to shift our current demand from P3 to P2 and P2 to P1, ensuring the right pathways are being maximised.
- Torbay will continue to invest in the VCSE sector including; VCSE hospital in-reach and medium-term support in the community to avoid readmission.
- Wider BCF investments will focus on Hospital Discharge Hub teams and Rapid Response services.

We recognise that the admissions avoidance space is equally as important to ensure flow within UEC, and our out of hospital teams for discharge under DTA and Admissions avoidance under UCR complement each other and work closely together to ensure the right care is delivered in the right place at the right time. Investment into the VCSE sector for well-being co-ordination will also support admission avoidance.

Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans

The development of goals set against the three-headline metrics of the BCF plan have been created where appropriate in-line with the NHS Operating Plan.

Emergency Admissions to hospital for people over 65

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,754	1,833	1,714	1,952	1,780	1,820	1,978	1,807	n/a	n/a	n/a	n/a
	Number of Admissions 65+	665	695	650	740	675	690	750	685	n/a	n/a	n/a	n/a
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	n/a	n/a	n/a	n/a
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
	Rate	1,641	1,672	1,588	1,670	1,625	1,588	1,738	1,638	1,722	1,688	1,662	1,635
	Number of Admissions 65+	622	634	602	633	616	602	659	621	653	640	630	620
	Population of 65+	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913

Our goals for reducing the number of admissions for individuals over 65 to hospital directly aligns to our approach as set out with in our 2025/26 operating plan response. The Devon approach centres on our Out of Hospital Transformation programme which sets out sustainable models for community service delivery and support/enable the shift from acute to community provision. Across our operating plan approach, we have articulated plans that strengthen the community service provision and provide targeted interventions that keep people out of hospital wherever possible. This aligned to our Home-Based Intermediate Care re-commissioning, will strengthen capacity not only through discharge but also ensure access to reablement staff in admission avoidance space.

Services and investments made through our BCF and wider system funding, includes initiatives such as the:

- **Urgent Community Response** which has a jointly designed Devon specification, signed up by all UCR providers across Devon with all 3 meeting the specification and NHSE delivery expectations, and an aim to continue to develop and grow the service.
- **Virtual wards** in Devon have an agreed specification, supporting 10 standard clinical conditions and the RDUH Trust in Devon consistently meets all virtual ward KPI's.
- Further detail of admission avoidance schemes have already been discussed earlier in this document. This programme of activity has been developed throughout 2024/25 and will

continue into 2025/26. This has allowed us to implement a stretch target for Emergency Admissions.

Discharge Delays - Average length of discharge delay for all acute adult patients

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.29	0.22	0.37	n/a	n/a	n/a	n/a
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	91.5%	91.8%	88.3%	n/a	n/a	n/a	n/a
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	3.4	2.7	3.2	n/a	n/a	n/a	n/a
	Apr 25 Plan	**May 25 Plan**	**Jun 25 Plan**	**Jul 25 Plan**	**Aug 25 Plan**	**Sep 25 Plan**	**Oct 25 Plan**	**Nov 25 Plan**	**Dec 25 Plan**	**Jan 26 Plan**	**Feb 26 Plan**	**Mar 26 Plan**
Average length of discharge delay for all acute adult patients	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43
Proportion of adult patients discharged from acute hospitals on their discharge ready date	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

There are a range of investments that directly attribute to delivering our improvements against this essential metric. The Torbay Hospital Discharge programme already discussed previously within this document is a key contributor to achieving this metric. Plans described in the Hospital Discharge Programme align to the NHS Operating Plan submission. The Hospital Discharge Programme is managed through a collaborative improvement programme, bringing together commissioners (health and social care) along with acute, community partners and the VCSE. This includes oversight of key internal flow metrics to enable real time monitoring of the use of DRD's to support tracking of forthcoming discharges and enable horizon scanning of any surges in capacity requirements.

Discharges for 25/26 include:

- **Reducing Length of Stay**: Increasing the percentage of patients discharged by or on day seven of their admission.
- **Enhancing Patient Flow**: Working with local authority partners to streamline discharge processes and reduce the average length of stay.
- **Leveraging Digital Tools**: Fully utilizing digital tools to transition from analogue to digital systems, improving efficiency and patient care.
- **Shift from Hospital to Home**: Emphasizing the transition from hospital care to home care, ensuring patients can recover in the comfort of their own homes.
- **Integrated Care**: Enhancing collaboration between health and social care services to provide seamless support for patients during discharge.
- **Support for Independent Living**: Implementing strategies to help people live independently, reducing the need for prolonged hospital stays.
- **Streamlined Processes**: Simplifying planning and reporting processes to improve efficiency and accountability.

The BCF directly funds a range of services that deliver the Discharge to Assess model within the city and capacity to ensure and enable a timely discharge from hospital. This includes:

Pathway 1:

- Reablement Pathway 1 specification – reablement focused short term interventions to support individuals in meeting rehab/reablement goals
- Home Based Intermediate Care – this is delivered by specialist reablement workers, operating under care plans designed with clear therapy goals and interventions. This is more intensive than the Hospital to Home service but enables a tailored resource to flex to individual need.

Pathway 2:

- A range of dedicated commissioned units, "Jack Sears", currently located in Torquay. 2025/26 commissioning intentions will be to consolidate the reablement P2 specification and reflect on its impact on wider P2 short term services.
- Spot purchase beds, commissioned with a warp around community-based therapy team along with an enhanced medical cover arrangement. This service operates in tandem to flex and respond to individual need and support individuals in achieving therapy goals and onward assessment activity to enable return home.

Residential Admissions - Long term support needs of older people met by admission to residential and nursing care homes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	762.3	701.6	830.8	817.7	807.1	796.6	786.0
	Number of admissions	289	266	315	310	306	302	298
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913

In the 2023-25 BCF plan we described how Devon ICS footprint had faced a significant challenge in the years following the pandemic with a rapid growth in the proportion of individuals needs who were being met through a care home admission, and that our plan for these 2 years sought to stem the rapid increase. We described how in the context of the demographic pressures facing the Devon system our ambitions of maintaining a steady position was ambitious.

During 2024/25 our plans to reduce the numbers of people moving into long-term residential care have not been achieved. Reflecting on the Q3 2024/25 position Torbay was performing at a rate of 862.5 per 100,000 population. 2025/26 metrics have been amended to reflect this position. Whilst the target is higher than 2024/25 this still provides a stretch target for the 2025/26 financial year.

We are more confident this year of our ambition and have assumed that the existing approaches (outlined below) will continue to manage the pressure we face, however, we also believe that our connected work on hospital discharge improvement and principally furthering our Home First approach will have a significant impact on improving our performance on this metric. Placing fewer people into residential beds on discharge and supporting people via therapeutic led models of P2 reablement beds will reduce the risks of deterioration/dependency and thereby reduce the risks of them converting to longer term care.

The main focus of work will be aligned to the development of Neighbourhood Health Teams (discussed above) and utilise guidance from the High Impact Change Model - Reducing preventable admissions to hospital and long-term care. The model focuses on two goals and five high impact changes that help realise one or both goals.

The two goals are:

- Goal 1: Prevent crisis: Actions to prevent crises developing or advancing into preventable admissions
- Goal 2: Stop crisis becoming an admission: Actions to divert or prevent an attendance at A&E becoming an admittance to hospital or long-term bed-based care

The five high impact changes and the goal or goals they relate to:

- Change 1: Population health management approach to identifying those most at risk
- Change 2: Target and tailor interventions and support for those most at risk
- Change 3: Practise effective multi-disciplinary working
- Change 4: Educate and empower individuals to manage their health and wellbeing
- Change 5: Provide a coordinated and rapid response to crises in the community

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

A review of 2024/25 Torbay Demand and Capacity plan has been undertaken as part of the BCF 2025/26 planning approach. A comparison of Q1-Q3 planned and reported data has informed the development of 2025/26 demand and capacity plans.

Table 1 illustrates the planned discharges between April and December 2025 across pathways 1 – 3. Table 2 illustrates actual data reported in BCF quarterly Demand and Capacity returns.

Table 1

Torbay	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total	%
P1 Planned	57	59	57	58	58	59	59	59	59	**525**	**54**
P2 Planned	38	39	39	39	38	39	39	39	38	**348**	**36**
P3 Planned	11	11	12	11	12	11	11	12	11	**102**	**10**
Total	106	109	108	108	108	109	109	110	108	**975**	**100**

Table 2

	Block									Spot											Difference against planned
Torbay	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total	%	%
P1 Actual	87	85	90	93	69	68	81	92	93										758	62	44%
P2 Actual	4	4	10	18	15	25	21	12	20	40	25	19	25	22	24	35	20	19	358	30	3%
P3 Actual										10	10	12	16	14	7	5	13	8	95	8	-7%
Total	91	89	100	111	84	93	102	104	113	50	35	31	41	36	31	40	33	27	1211	100	24%

2024/25 reported data indicates an 24% overall increase in discharges / people accessing combined P1-3 provision. Based on reported data there is variance against planned activity. Variance between recorded data for each pathway is as follows; pathway 1 (44%), pathway 2 (-3%) and pathway 3 (-7%). Local data has been cross referenced with SUS data to check validity. Data quality has improved throughout 2024/25 and we are assured by the data to be able to set realistic Demand and Capacity plans for 2025/26.

Torbay's 2025/26 demand and capacity plan has taken into account:

- 2024/25 actual performance and assumes
- 3.5% uplift based on SUS data, expected increased in UEC demand and flow through to complex discharges.
- Pathway 1 data provides block booked arrangements (in-house and independent sector provision). Average monthly discharges equate to capacity for 78 discharges per month. Within our commissioning arrangements Torbay has built in extra capacity to manage up to 137 P1 discharges per month.
- Pathway 2 assumes a two-model delivery, (block) reablement and short term services rehab / recover (spot).
    - Based on 2024/25 performance, block contracts assume 26 step down beds, operating at 70% occupancy with a 21 day average LoS. This provides additional capacity and room to support a further 9-10 discharges per month through our specialist therapy led model.
    - Spot provision will be procured as required and assumes a 28 day average LoS.
- Pathway 3 will all be secured via spot purchases to allow flexibility and with the aim to further reduce P3 utilisation.

It should be noted the Torbay Demand and Capacity template reflects the expected number of discharges across pathways 1 – 3. The additional capacity (described above) and flexibility to support our aspirations to move discharge quotas from P3 to P2 and P2 to P1 is not reflected in the demand and capacity template.

During 2024/25 procurement activity has been undertaken. Pathway 2 saw the introduction of Jack Sears, Torbay's specialist therapy led reablement centre. This is showing a positive impact on patient outcomes. The broader impact on P2 provision will be closely monitored in 2025/26 to help explore any further transformational and commissioning activity required in P2 provision.

In 2025/26 a new reablement specification will be launched, taking learning from partners in the Devon County Council footprint to drive further improvements in this area.

The Torbay Demand and Capacity Plan is based on current performance with expected increase in forecasts. The BCF plan discusses our aspiration to see a positive move in discharges from P3 to P2 and P2 to P1. The flexibility in Torbay provision has been described above. However, detailed plans will be created as part of a wider Devon ICS programme of activity. Trajectories will be amended in Torbay's BCF D&C plan in coming months.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

- Do you have any improvement plans to support therapy capacity for rehabilitation and reablement interventions or good practice you can share?

Intermediate care supports recovery and rehabilitation at home or in community settings, typically for up to six weeks, aiming to improve patient flow by enabling timely discharges and reducing unnecessary hospital admissions. The NHS England pilot (2024/25) in seven regions, including Devon, focused on refining workforce planning and addressing gaps in service provision for intermediate care.

Royal Devon and Exeter University Hospitals NHS Foundation Trust (RDUH) manages Short-term Services Teams (STST) across clusters in North Devon and Eastern regions like Exeter, East, and Mid-Devon.

These teams provide community rehabilitation services lasting up to six weeks, alongside community nursing.

Integration with wider Adult Health and Social Care teams ensures holistic support. STST's support extends to Woodland Vale Care Home in Torridge, providing community rehab and recuperation beds via joint commissioning arrangements with other stakeholders.

Torbay and South Devon NHS Foundation Trust (TSDFT) collaborates with Devon County Council (DCC) to deliver cross-organisational intermediate care services across four locality footprints.

This includes community rehabilitation, reablement services, and unplanned community interventions through Integrated Care (IC) teams, Urgent Care Response (UCR) teams, and rapid response teams.

While staffing models vary between localities, there's integration across TSDFT and DCC/TC ASC teams to ensure seamless care delivery.

The below table provides a summary of service models and how community rehabilitation and reablement is provided across Devon. The below is not extensive of all arrangements but provides a helpful snapshot of approaches.

D2A	Who (provider)	Who (team)	What	Where	How
P1	DCC	Social Care and Reablement (SCR), provided across three places.	SCR teams provides community reablement (≤3 weeks).	One SCR team per place, covering: • North Devon • East Devon • South Devon	• Different models across each place, as determined by ICS's devolution of decision-making to place • North and South Devon places deliver SCR with a support workforce only; East Devon includes OT oversight and input
P1	RDUH (North Devon)	Short-term services teams (STST), nested within the wider Adult Health and Social Care teams (HSCTs), with one of these across each cluster supported.	The STST provides: • Community rehab (≤6 weeks) • Community nursing Wider HSCTs provide: • Respiratory services • Lymphoedema services • Pathfinder team *(Northern clusters only)*	One HSCT per Northern cluster: • Ilfracombe and South Molton • Barnstaple • Torridge • Holsworthy, Bude and surrounding villages	• Different staffing models between Northern and Eastern teams as a result of Trusts merging in 2022 • In each cluster, there is a shared staffing model across HSCTs to cater for large geography and high travel times • Integrated with DCC adult social care (ASC) teams, although limited day-to-day support between support workers and therapy leads • Supported by the voluntary and third sector
P1	RDUH (Exeter, East and Mid-Devon)			And one per Eastern cluster: • Crediton, Moretonhampstead and Okehampton • Honiton, Ottery St Mary and Cranbrook • Exmouth, Woodbury, Budleigh • Exeter (South and West) • Exeter (Central and East) • Tiverton and Cullompton • Sidmouth, Seaton and Axminster	
P2	Woodland Vale Care Home	STST supports care home staff	• Community rehab beds • Community recuperation beds	Provided in Torridge (Torrington)	• Support provided by STST • Block-purchased via joint commissioning arrangements with ICB and DCC
P1	TSDFT and DCC	Cross-organisational intermediate care (IC) services, provided across four locality footprints. There are also two UCR teams and two rapid response teams.	IC teams provide community rehab and reablement services. UCR and rapid-response teams are also provided across the patch to deliver unplanned community interventions and reablement where needed.	One IC team per locality, covering: • Moor-to-Sea locality • Coastal locality • Newton Abbot locality	• Different IC staffing models between locality teams, with some leaning more heavily on unregistered staff compared to registered staff • Four UCR and rapid response teams also provide reablement across TSD under a UCR umbrella • Standalone specialist community rehab stroke and neuro services are provided separately, and are out of scope • Some integration across TSDFT and DCC/TC ASC teams
P1	TSDFT and TC			One IC team in Torbay locality	
P2	TSDFT	Individual community hospital teams from TSDFT, supporting numerous community hospitals and care homes.	Bed-based care and support provided by community hospital teams and care home leads, with some in-reach and specialist support provided by community teams as required.	Five community hospital sites across: • Brixham Community Hospital • Dawlish Community Hospital • Newton Abbot Community Hospital • Teignmouth Community Hospital • Totnes Community Hospital	• Community hospital teams support patients receiving P2 bedded care in the relevant community hospital • Specialist therapy teams provide support where required for patients with neurological needs • TSDFT has recently introduced 'care home lead' roles which are joint-funded from nursing and IC teams to work alongside care homes where relevant in-house capability does not exist for patients in bedded care in care homes

The approach for Torbay, through our intermediate care plan delivery focuses on the step change in P3 to P2 and P2 to P1 activity which will as a result delivery benefits for releasing therapy and assessment capacity to focus on Home based intermediate care delivery. We are also in the process of working up plans to ensure that our home-based intermediate care services in Devon (Hospital to Home and DTA) are maximising opportunities to work closer together to improve patients' outcomes, efficiency and productivity.

The externally commissioned Rapid Support Service (RSS), addresses the short-term reablement needs of Devon residents as part of the wider Intermediate Care system. The RSS model shifts from reactive, task-focused long-term care to a supportive reablement approach, emphasising prevention, early intervention, and progression. The goal is to help individuals achieve greater independence, enhance their well-being, and reduce reliance on long-term care.

Key outcomes include:

- **Faster Recovery**: Encouraging positive risk-taking to help individuals regain independence after illness or adverse health events.
- **Living independently at Home**: Enabling people to live safely at home for longer, improving quality of life through a strengths-based approach.
- **Outcome-Focused Care**: Transitioning from time and task-based care to outcome-focused delivery with a skilled, innovative workforce.
- **Pathway 1 Discharges** (care at home): Increasing the number of recoveries at home to prevent long-term residential or nursing care placements.
- **Reducing Delays**: Alleviating care transfer delays between health and social care systems, reducing avoidable hospital admissions and demand for long-term services.

Key highlights of our Intermediate Care services workforce are:

- The age distribution of NHS staff in Devon is slightly lower (-3%) than the national average, meaning its workforce has fewer people over the age of 55 than other models across the country
    - RDUH and TSDFT have a blended average of 18% of staff aged ≥55, with RDUH's workforce being slightly younger
- In DCC, however, this proportion is over double that of its NHS partners with 36% of staff aged ≥60
    - This is almost 10% higher than the national average for social care staff, and may pose a medium-term risk for the council
- The proportional distribution of teams' staff bandings is closely mirrored between RDUH and TSDFT
    - On average, 46% of the workforce is Band 5 and above
- The blended average banding of staff shows that the majority of each Trust's workforce comprises 32-35% of Band 3s, with a very small proportion of Band 4s present
    - Similarly, over 90% of DCC's SCR team are Band 3s
    - This could represent a potential opportunity for growth into Band 4 and Band 5 career pathways across Devon as an ICS
- Where known, turnover rates (RDUH) and vacancies (TSDFT) are:
    - slightly lower than the national averages for each metric
    - significantly lower than those of the other sites
- In RDUH, turnover rates have dropped materially in the last 12 to 18 months across both the registered and unregistered workforce; this could indicate successful initiatives to retain staff
- In TSDFT, the primary role vacancies experienced are (rehab) support workers; this could represent an opportunity for further career pathway development through Bands 4 and 5 to support recruitment

Devon's Intermediate Care Modelling pilot (2024) and subsequent Devon Intermediate Care Report (2025) highlighted opportunities to develop a core model and vision which enables local variation on top of a consistent foundation along with better data and intelligence to support demand and capacity. This features within our Hospital Discharge Transformation plans discussed earlier in this document.

Key considerations which will be further explored in 2025-26 include:

- Expand Band 4 roles with targeted training.
- Streamline Pathway 1 processes and improve equipment logistics.
- Enhance goal-setting practices and care alignment using standardised templates.
- Increase engagement with voluntary and community resources.
- Develop validated outcome measures for intermediate care.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Within Torbay, as part of the development of our Adult Social Care Strategy - Torbay Council we have co-produced our vision for Adult Social Care with our community, voluntary and care sectors working in partnership with Torbay Council and Torbay and South Devon NHS Foundation Trust staff as we work to deliver improved adult social care services for residents in Torbay.

Our shared vision is:

Thriving communities where people can prosper.

Our mission statement is:

We will work with our local community to support residents in Torbay to maximise their own wellbeing and independence, advising and guiding them around the best health and social care systems for them. Those who offer and provide support services will feel empowered to enable people to engage fully in their own decision making on choices of care. By working with our community this way, we will create a new way of supporting each other to achieve wellbeing for everyone - those receiving support and personal assistance and those giving it.

In particular, our system of care and support will be:

- **Focused on outcomes and wellbeing**
  Care and support is focused on promoting our wellbeing in all its facets – physical, mental, emotional and spiritual – and the outcomes we decide are important to us.

  It also promotes equity and inclusion by ensuring different groups in the population experience similar outcomes.

- **Personalised, co-created and flexible**
  We have a say and shape care and support both individually and at community/ local level.

Care and support adapts to our needs as they change, and recognises our diversity and individual preferences, beliefs and circumstances. When we lack capacity there are advocates to represent our prior wishes and best interests. When needed people will be supported by appropriate interpreting services and advocacy.

- **Proactive and preventative**
  We can access support to enhance our health and wellbeing and reduce inequalities across communities. Care and support is easily available at an early stage to help slow or prevent escalation into crisis, or before we have acute care needs.

For further information please see our Adult Social Care Strategy - Torbay Council

Engagement

People and Communities Framework

The draft One Devon People and Communities Framework has been developed and is awaiting sign off through the relevant governance channels. The Framework demonstrates how working together across the system widens the opportunity of engagement to the whole population, ensuring that the voices of those who experience health inequalities, or those who live in rural, coastal or remote locations have an equal chance to be heard and influence decision-making.

Devon Engagement Partnership

The Devon Engagement Partnership (DEP) is the vehicle that will support One Devon in effectively and meaningfully listening to and working with people and communities across Devon. The membership includes representation from LCPs, Healthwatch, VCSE organisations, provide and acute colleagues and NHS Devon.

One Devon Insight Library

The starting point for any engagement should be – "what do we already know?". The One Devon insight library brings together all the insights from engagement by NHS Devon and key system partners since 2018. This library of insights is currently available in an offline version but the vision over the next 12 months is to have this a searchable library as part of an online engagement platform.

Devon 10 Year plan engagement programme

The Devon 10-year plan engagement programme has been extensive, and views have been sought from across the county. To date, over 3000 pieces of individual feedback has been received that provides a representative view from across the County. As part of the programme – 5 engagement days took place – 1 held in Paignton and 1 in Ivybridge.

The findings from this engagement are going to inform the development of the national 10-year health plan whilst informing local priorities and pieces of work.

The 10-year clinical strategy has a vision of delivering outstanding integrated care, unlocking better outcomes, reducing inequalities, and improving lives across Devon and the wider region. The strategy represents the start of a long-term programme of change, clinical transformation journey and defines the basis for collaboration- putting the needs of the patients and population at the heart of integration. The strategy, clinical models and associated work has had input and co-

development from partners including the ICP, LCP and ICS' (Devon and Cornwall). Collaboration between these partners is integral for the continual development and delivery of interlinked strategies. Years 2-5 of the clinical strategy focus on meeting local need to deepen place-based integration and develop end-to-end patient pathways, implement data-driven population health management approaches to care and to develop digital infrastructure to support PHM and networked care.

To improve services for disabled people, the Health and Care Act, since 2022, has had an explicit focus on addressing health inequalities. Many disabled people live in a home that is not adapted to their needs – we know that a decent home is the foundation for an independent life. Funding provided by the BCF ensures those with a disability have an equal opportunity to remain living independently, with the adaptations likely to improve the health and wellbeing of those individuals. The planned strategies to be deployed across 2025-26 will enhance provision, options, speed, compliance, and demand versus need, and will contribute to the addressing of inequalities through an improved service. This will involve health and care services working with local communities and the VCSE to deliver CORE20Plus5 targets and implement high impact interventions.

Carers' health is known to be worse than that of non-carers due to the pressures of the role and is why Carers UK are calling for GP practices to identify carers quickly and to promptly inform of services available to help them look after their own health and wellbeing. The BCF funding ensures there is a service advocating for carers and thus contributes to the addressing of health inequalities.

One Devon signed a commitment to carers through a number of pledged principles, demonstrating a recognition of the value and contribution made by unpaid carers. The principles include the identification and supporting of carers, enabling informed choice, staff awareness, information sharing, effective support, respecting carers as experts and carers roles who are changing or more vulnerable.

A renewed and informed focus on Equality, Diversity & Inclusion (EDI) ensures services for patients take a considered approach to their delivery and actively seek to reduce differences in outcomes and inequalities. The vision is for EDI to be embedded in everything we do, and we are proud of the work to date to make this ambition a reality. While our organisational cultural competence is increasing, and the importance and recognition of EDI across the system is growing, there is a recognition there is still work to do. Our strategies describe an innovative approach to inclusion that prioritises co-production and collaborating with community partners to understand the needs of our diverse communities in Devon. Inclusion should be at the heart of organisational cultures and is set to be the foundation of joint working across our system.

Population Health Management (PHM) is an enabler in the aim of reducing health inequalities. The PHM programme will guide our primary care networks to identify and target specific patients and populations at risk of deteriorating physical and mental health due to factors such as social vulnerability and long-term conditions. The programme, and the linked One Devon Dataset, will provide health & care systems with data / intelligence to identify and provide proactive and evidence based integrated care for key population groups using digital and direct means to support people to live and manage their conditions in their communities and reduce inequalities in health

and wellbeing. For our commissioned services, Equality Impact Assessments are completed for key decisions, and include consideration of census and other population data.